Developing the "Why" Facet of Medical Professionalism

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Numerous articles have been published that discuss medical professionalism from the perspective of "what-to-be" and "what-to-do". In this paradigm, for doctors to effectively execute the "right" attitudes and behaviors, they must incorporate a "know-how" attitude or "reflective practice" into their professional lives. However, definitions of "what" change over time in an evolving social context. For physicians to be able to continue incorporating the right new attitudes and behaviors, they must also develop a "know-why" perspective. The health care market follows the criteria of a "market for lemons". The high degree of information asymmetry seen in health care is a strong risk factor for adverse selection, producing an excess of defective articles of commerce in the market. In this case, the processes of signaling and screening, two known solutions for adverse selection in general, cannot bridge the information gap between patients and doctors, since patients must put their lives and their privacy into doctors' hands. Professionalism, therefore, is used by doctors to win the trust of patients, their caregivers and society at large. This is the "why"-level intellect, in which the physician sets developing public trust as a goal for his own self-actualization and develops it in conjunction with altruism. This is a key to success for the physician as a doctor and as a person.

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From the Oath of Hippocrates to the New Physician Charter [1], numerous authors have attempted to define medical professionalism. Their writings attempt to inform physicians what they should be and what they should do. As with other facts and understandings in medical science, many of these "what" mandates change with time, while others remain more permanent. These "what" concepts do not instruct physicians as to whether their knowledge is sufficient, or whether they themselves are right or wrong.

In recent years, medical education has emphasized incorporating evidence-based thinking into clinical problem solving. Once a physician has learned this process, s/he is capable of knowing what to learn continuously, even in this era of rapidly progressing medical science and technology. Physicians are expected to know the best available evidence, and to judge whether information learned in the process of researching a clinical question is valid or not.

Applying this perspective to medical professionalism is somewhat more difficult. In this review, I will explore how medical professionals attempt to continually re-evaluate what they know about how they must act and what they should do in a rapidly changing social context.

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Hierarchy of Intellectual Knowledge

According to Quinn and colleagues [2], there are four levels of professional intellect: (1) cognitive knowledge ("know-what"); (2) advanced skills ("know-how"); (3) systems understanding ("know-why"); and (4) self-motivated creativity ("care-why"). Acceptance of what physicians should be and what they should do can be written into standard "what" definitions of medical pedagogy. Through this instruction, physicians can become cognitively knowledgeable about professionalism. This knowledge may not be practical enough, however, as the Chinese proverb says: "Give a man a fish and he will eat for a day. Teach him how to fish and he will eat for a lifetime." Professional behaviors and attitudes are highly context-dependent and require day-to-day hands-on learning to achieve mastery. As Quinn and colleagues described, this translates book learning into effective execution. For physicians, incorporating "reflective practice" [3]—how to fish—into daily professional life is the most effective way to act on knowledge of what to be and what to do.

However, under rapidly changing social situations, this does not guarantee that physicians will be competent at professionalism for a lifetime. Critical to this endeavor is the knowledge of why the physician was taught professionalism in the first place. This know-why, deeper knowledge enables physicians to act right even in new or unexpected situations. For example, taking on an authoritative attitude towards patients may have been the proper way to act as a medical professional in the earlier part of some physicians' careers, but as societal needs and expectations have changed, the process of shared decision-making has become a standard aspect of the patient–doctor relationship. Understanding how this know-why level of knowledge is developed is critical to assessing how physicians adapt.

The Three-circle Model of Outcome-based Medical Education

Harden and colleagues' *three-circle model* [4] is a simple and compelling explanation of the set of core competencies required of all physicians. First, physicians must perform their tasks well; this is placed within the center circle. Examples of tasks required of the physician include physical examinations, the surgical excision of an inflated appendix, the presentation of cases, and the management of chronic medications. Next, physicians must perform these tasks under the right manner of thinking; this is placed in the second circle. Examples of this thinking include the evidence-based selection of diagnostic tests and interventions, and ethical decision-making in end-of-life care. Finally, the outer, third, circle is professionalism. But why do physicians need to have this in addition to being capable of performing their tasks well under the right way of thinking?

The Market for Lemons

A problem arises in that, owing to the complexity of medical care, patients, their caregivers and the lay public typically cannot determine whether a doctor is providing effective or evidence-based care. This creates a market with information asymmetry [5], in which doctors are information-advantaged relative to patients and their caregivers.

Asymmetric information is a strong risk factor for market failure. One popular example is the used car market, where end users (potential buyers) are not typically capable of judging the quality of the product before their purchase. Bad used cars are called "lemons" by insiders since bad lemons cannot be distinguished from good lemons merely by assessing their surface. When buyers have doubts about the quality of the product, they will not pay extra money for potentially good products (so-called "cherries"). In the case of the used car market, because sellers cannot sell cherry cars at a price commensurate with the value of the car, they often remove the cherry cars from the market. As the fraction of cherry cars in the market diminishes, buyers refuse to pay the same high price for cars with the same value as before, and used car prices plummet. As a result, fewer still cherries appear in the market, and this vicious cycle continues until the market eventually collapses. In information economics, this phenomenon is known as adverse selection.

Similarly, when patients feel that there is a considerable chance of seeing a lemon doctor, they may tend to visit larger hospitals on the assumption that doctors in larger hospitals are better (a phenomenon that

might be called surrogate selection). This is particularly the case in Japan, where any consultation, diagnostic test or intervention by any doctor at any hospital or clinic is set at a uniform price. As a result, patient loads increase, and the quality of specialized medical services declines. Additionally, "cherry" doctors at smaller hospitals/clinics tend to become "lemons" because their efforts are not rewarded—man needs to be both externally- and internally-motivated to maintain the right attitude. This adverse selection process can have a devastating effect on the quality and efficiency of the health care system.

In general, there are two solutions for adverse selection. The first strategy, known as signaling, is the delivery of signals from the seller to the buyer, providing assurances about the quality of the goods or services being provided. In the used car market, examples of signaling include joining the Automobile Fair Trade Council and displaying the certificate in the shop, and enacting legislation that stipulates that used car traders must disclose model year, total mileage and the repair record of all used cars. In health care provisions, physicians are expected to complete residency programs and specialty board certifications at accredited hospitals and to put these certifications on display in the office for patients to inspect. Hospitals require accreditation by an authorized third party.

The second strategy, screening, is to conduct some form of screening test to measure the quality of the information-advantaged party. Employment examinations are one example; in this case, the potential employer is the information-disadvantaged party since he does not know the quality of the applicant pool. In health care, patients might want to bring a screening quiz to their physicians at the first visit, using this to perhaps ask questions about the number of malpractice lawsuits the doctor is facing, the rate of appropriate antibiotic prescriptions to patients with sore throats, or the average number of post-surgical hospital days for the physician's patients.

Despite large uncertainties inherent in medical practice, patients are expected to entrust their privacy and their lives to physicians. Whatever signals physicians attempt to send to patients, caregivers and the general public, they are typically not enough to close the huge information gap. As such, this gap can only be filled by trust between the health care provider and patients. One definition of professionalism is, therefore, the art of making every effort to obtain trust with patients, caregivers and the general public.

It is often claimed in Western countries that certain professions are granted a monopoly over the use of a body of knowledge, as well as considerable autonomy in practice and the privilege of self-regulation, prestige and financial rewards on the understanding that they will guarantee competence, provide altruistic service and conduct their affairs with morality and integrity [6]. This concept is generally described as a social or unwritten contract between a profession and society. It must be remembered, however, that although there must be mutual trust to leave this contract unwritten, this is not the main reason why the "what-to-do" behaviors of physicians are necessary in the patient–doctor relationship. Physicians need to develop trust to effectively provide value in the services they offer to their patients [7], not merely to obtain the rewards patients can offer to them.

"Why" and "Care-why"

The preceding discussion can provide a "why" definition of medical professionalism. It is worth visiting some of these definitions provided by other authors. Swick states, in his article entitled *Toward a Normative Definition of Medical Professionalism* [8], that "medical professionalism consists of those behaviors by which we as physicians demonstrate that we are worthy of the trust bestowed upon us by our patients and the public because we are working for the patients' and the public's good." In *Doctors in Society* by the Royal College of Physicians of London [9], medical professionalism is defined as a set of values, behaviors and relationships that underpin the public's trust in doctors.

The Physician Charter [1] demonstrates three fundamental principles of medical professionalism: (1) the primacy of patient welfare; (2) patient autonomy; and (3) social justice. These three principles do not provide a rationale for the necessity of professionalism, but rather, are the core values that physicians aspire to deliver to their patients; they represent the reasons, the "whys", for providing medical service.

On the other hand, physicians typically do not seek to develop trust for its own sake, but rather for the utility it provides in delivering effective medical care. It is my belief, however, that developing trust

with patients can be one of the greatest rewards for physicians and that physicians can synergize their self-actualization with altruism and achieve a care-why level of thought and action.

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